Electronic Data Interchange Enhanced to Support Safety First Event Reporting

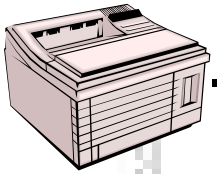
(SaFER)

- Partnering to protect our employees and meet our challenges

How does this work?

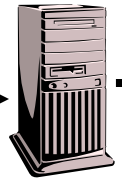
Employee Reports the injury to his/her supervisor

Supervisor and Employee complete the On-Line initiating claim form



Supervisor prints completed form

Injured employee signs the printed copy of the initiating claim form

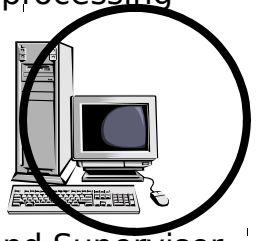


Supervisor electronically submits claim for processing

The responsible ICPA office is notified that a claim is awaiting authentication

ICPA reviews claim for accuracy, enters appropriate codes, corrects any errors and authenticates the claim

The responsible safety office and supervisor are notified that an accident occurred

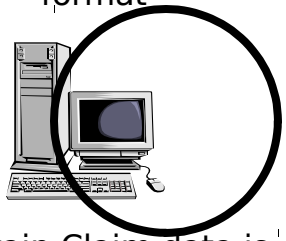


Safety and Supervisor receive an electronic OSHA-301 form in PDF format

Claim is batched for transmittal to OWCP

OWCP receives claim, validates data, and submits data to District OWCP for case number assignment

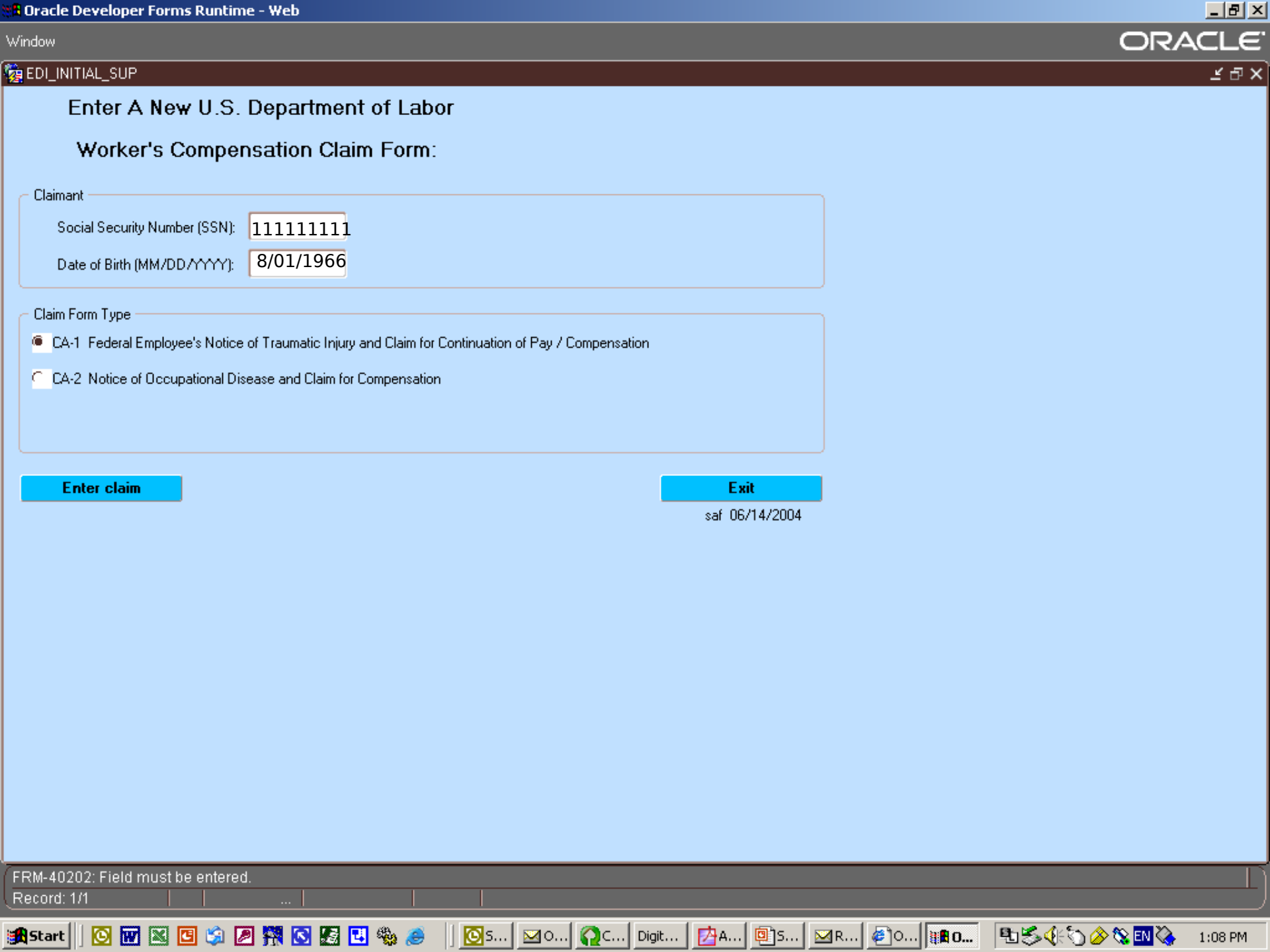
Claim Number is received at National OWCP and transmitted back to ICUC

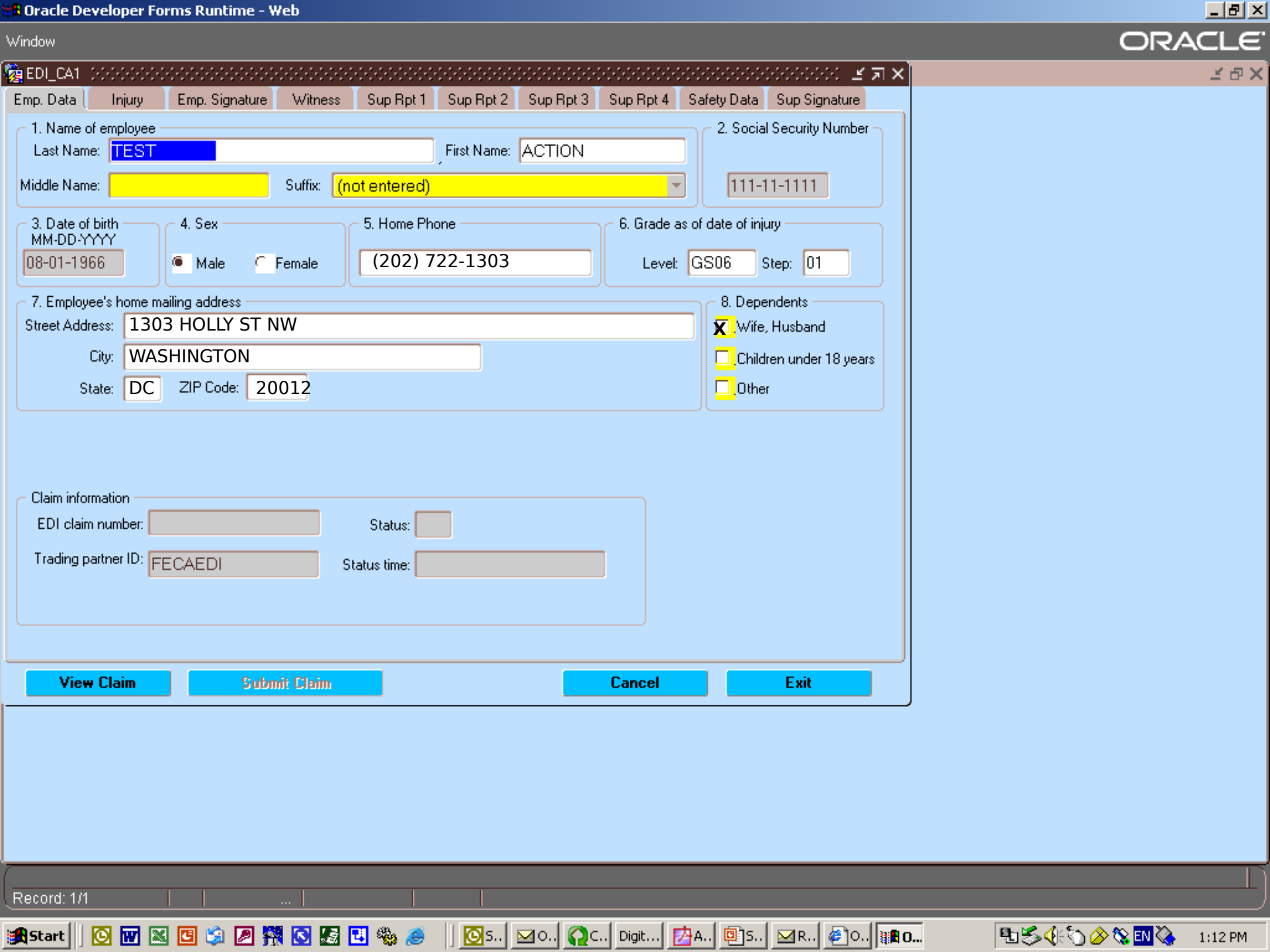


Certain Claim data is then loaded into the DIUCS2000 Case Management Module

Safety First Event Reporting

Demonstration


Oracle Developer Forms Runtime - Web
Window
ORACLE
EDI_INITIAL_SUP
Enter A New U.S. Department of Labor
Worker's Compensation Claim Form:
Claimant
Social Security Number (SSN):
111111111
Date of Birth (MM/DD/YYYY):
8/01/1966
Claim Form Type
CA-1 Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay / Compensation
CA-2 Notice of Occupational Disease and Claim for Compensation
Enter claim
Exit
saf 06/14/2004
FRM-40202: Field must be entered.
Record: 1/1
Start
1:08 PM


Oracle Developer Forms Runtime - Web
Window
ORACLE
EDI_CA1
Emp. Data
Injury
Emp. Signature
Witness
Sup Rpt 1
Sup Rpt 2
Sup Rpt 3
Sup Rpt 4
Safety Data
Sup Signature
1. Name of employee
Last Name: TEST
First Name: ACTION
Middle Name:
Suffix: (not entered)
2. Social Security Number
111-11-1111
3. Date of birth
MM-DD-YYYY
08-01-1966
4. Sex
Male
Female
5. Home Phone
(202) 722-1303
6. Grade as of date of injury
Level: GS06
Step: 01
7. Employee's home mailing address
Street Address: 1303 HOLLY ST NW
City: WASHINGTON
State: DC
ZIP Code: 20012
8. Dependents
Wife, Husband
Children under 18 years
Other
Claim information
EDI claim number:
Status:
Trading partner ID: FECAEDI
Status time:
View Claim
Submit Claim
Cancel
Exit
Record: 1/1
Start
1:12 PM

Oracle Developer Forms Runtime - Web

Window

ORACLE

EDI_CA1

Emp. Data | Injury | Emp. Signature | Witness | Sup Rpt 1 | Sup Rpt 2 | Sup Rpt 3 | Sup Rpt 4 | Safety Data | Sup Signature

9. Place where injury occurred (e.g. 2nd floor, Mainpost Office Bldg., 12th & Pine)

IN FRONT WALKWAY AT 1400 KEY BLVD, ARLINGTON VA

ZIP Code: 22209

10. Date & time injury occurred MM-DD-YYYY HH:MM [AM|PM]: 09-07-2004 12:00 AM

11. Date of this notice MM-DD-YYYY: 09-07-2004

12. Employee's Occupation Description: PERSONNEL ACTIONS CLERK (DATA TRANSCRIBING)

13. Cause of injury (Describe what happened and why)

WHILE WALKING INTO THE BUILDING FROM BREAK, I SLIPPED ON THE WET FLOOR. THE CUSTODIAN JUST WASHED THE MARBLE FLOOR AND IT WAS VERY SLIPPERY.

14. Nature of injury (Identify both the injury and the part of body, e.g., fracture of left leg)

SPRAINED LEFT ANKLE

a. Occupation code: 0203

Cause of injury code:

b. OSHA Type:

c. OSHA Source:

Nature of Injury:

Anatomical location code

Part of Body:

Side of Body:

View Claim | Submit Claim | Cancel | Exit

Record: 1/1

Start | 1:21 PM

Oracle Developer Forms Runtime - Web

Window

ORACLE

EDI_CA1

Emp. Data | Injury | Emp. Signature | Witness | Sup Rpt 1 | Sup Rpt 2 | Sup Rpt 3 | Sup Rpt 4 | Safety Data | Sup Signature

15. I certify, under penalty of law, that the injury descibed above was sustained in performance of duty as an employee of the United States Government and that is was not caused by my willful misconduct, intent to injure myself or another person, nor by my intoxication. I hereby claim medical treatment, if needed, and the following, as checked below, while disabled for work:

- [ ] a. Continuation of regular pay (COP) not to exceed 45 days and compensation for wage loss if disablity for work continues beyond 45 days. If my claim is denied, I understand that the continuation of my regular pay shall be charged to sick or annual leave, or be deemed an overpayment within the meaning of 5 USC 5584.
- [ ] b. Sick and/or Annual Leave
- [ ] c. Unknown

I hereby authorize any physician or hospital (or any other person, institution, corporation, or government agency) to furnish any desired information to the U.S. Department of Labor, Office of Workers' Compensation Programs (or to its offical representative). This authorization also permits any official representative of the Office to examine and to copy any records concerning me.

Signature of employee or person acting on his/her behalf _____ **Date** MM-DD-YYYY 09-07-2004

Any person who knowingly makes any false statement, misrepresentation, concealment of fact or any other act of fraud to obtain compensation as provieded by the FECA or who knowingly accepts compensation to which tat person is not entitled is subject to civil or administratrive remedies as well as felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment or both.

Have your supervisor complete the receipt attached to this form and return it to you for your records.

View Claim | Submit Claim | Cancel | Exit

Record: 1/1

Start

1:23 PM

Oracle Developer Forms Runtime - Web

Window

ORACLE

EDI_CA1

Emp. Data | Injury | Emp. Signature | Witness | Sup Rpt 1 | Sup Rpt 2 | Sup Rpt 3 | Sup Rpt 4 | Safety Data | Sup Signature

16. Statement of witness (Describe what you saw, heard, or know about this injury)

I SAW MR TEST FALL BECAUSE OF THE WET FLOOR. I WAS LEAVING THE BUILDING AFTER DELIVERING A PACKAGE

	Last Name	First Name	Middle Name
Name of Witness:	SNIPES	WESLEY	L

Signature of witness: _____ **Date signed:** 09/07/2004 (MM-DD-YYYY)

Street Address: 1475 FAIRFAX STATION RD

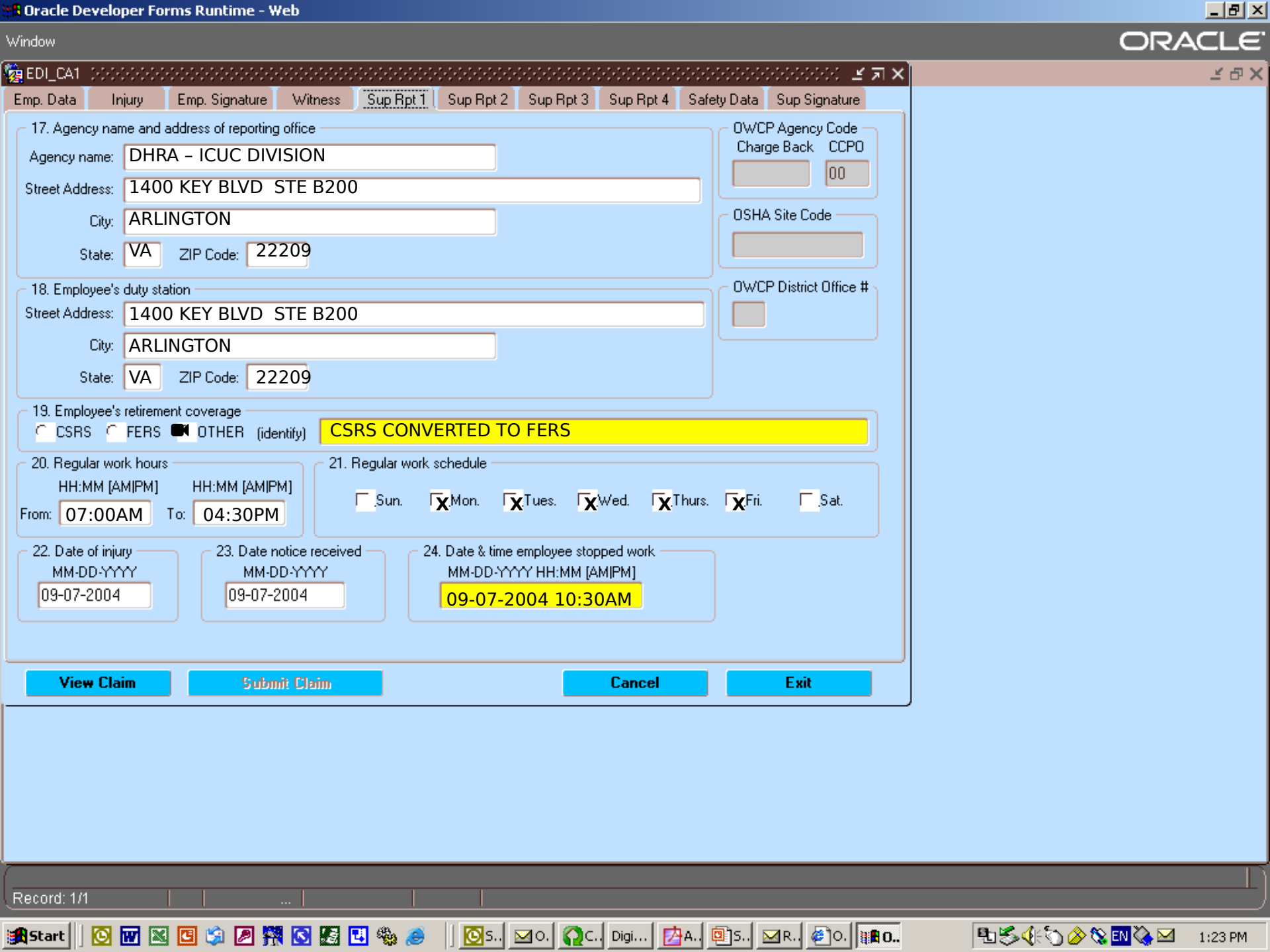
City: VIENNA

State: VA ZIP Code: 22243

View Claim | Submit Claim | Cancel | Exit

Record: 1/1

Start | 1:23 PM


Oracle Developer Forms Runtime - Web
Window
ORACLE
EDI_CA1
Emp. Data
Injury
Emp. Signature
Witness
Sup Rpt 1
Sup Rpt 2
Sup Rpt 3
Sup Rpt 4
Safety Data
Sup Signature
17. Agency name and address of reporting office
Agency name: DHRA – ICUC DIVISION
Street Address: 1400 KEY BLVD STE B200
City: ARLINGTON
State: VA
ZIP Code: 22209
OWCP Agency Code
Charge Back
CCPO
00
OSHA Site Code
18. Employee's duty station
Street Address: 1400 KEY BLVD STE B200
City: ARLINGTON
State: VA
ZIP Code: 22209
OWCP District Office #
19. Employee's retirement coverage
CSRS
FERS
OTHER
(identify)
CSRS CONVERTED TO FERS
20. Regular work hours
HH:MM [AM|PM]
From: 07:00AM
To: 04:30PM
21. Regular work schedule
Sun.
Mon.
Tues.
Wed.
Thurs.
Fri.
Sat.
22. Date of injury
MM-DD-YYYY
09-07-2004
23. Date notice received
MM-DD-YYYY
09-07-2004
24. Date & time employee stopped work
MM-DD-YYYY HH:MM [AM|PM]
09-07-2004 10:30AM
View Claim
Submit Claim
Cancel
Exit
Record: 1/1
Start
1:23 PM

Oracle Developer Forms Runtime - Web

Window

ORACLE

EDI_CA1

Emp. Data | Injury | Emp. Signature | Witness | Sup Rpt 1 | Sup Rpt 2 | Sup Rpt 3 | Sup Rpt 4 | Safety Data | Sup Signature

25. Date pay stopped
MM-DD-YYYY

26. Date 45 day period began
MM-DD-YYYY

27. Date & time employee returned to work
MM-DD-YYYY HH:MM [AM|PM]
09-08-2004 07:00AM

28. Was employee injured in performance of duty?
☐ Yes ☒ No (If "No", explain)

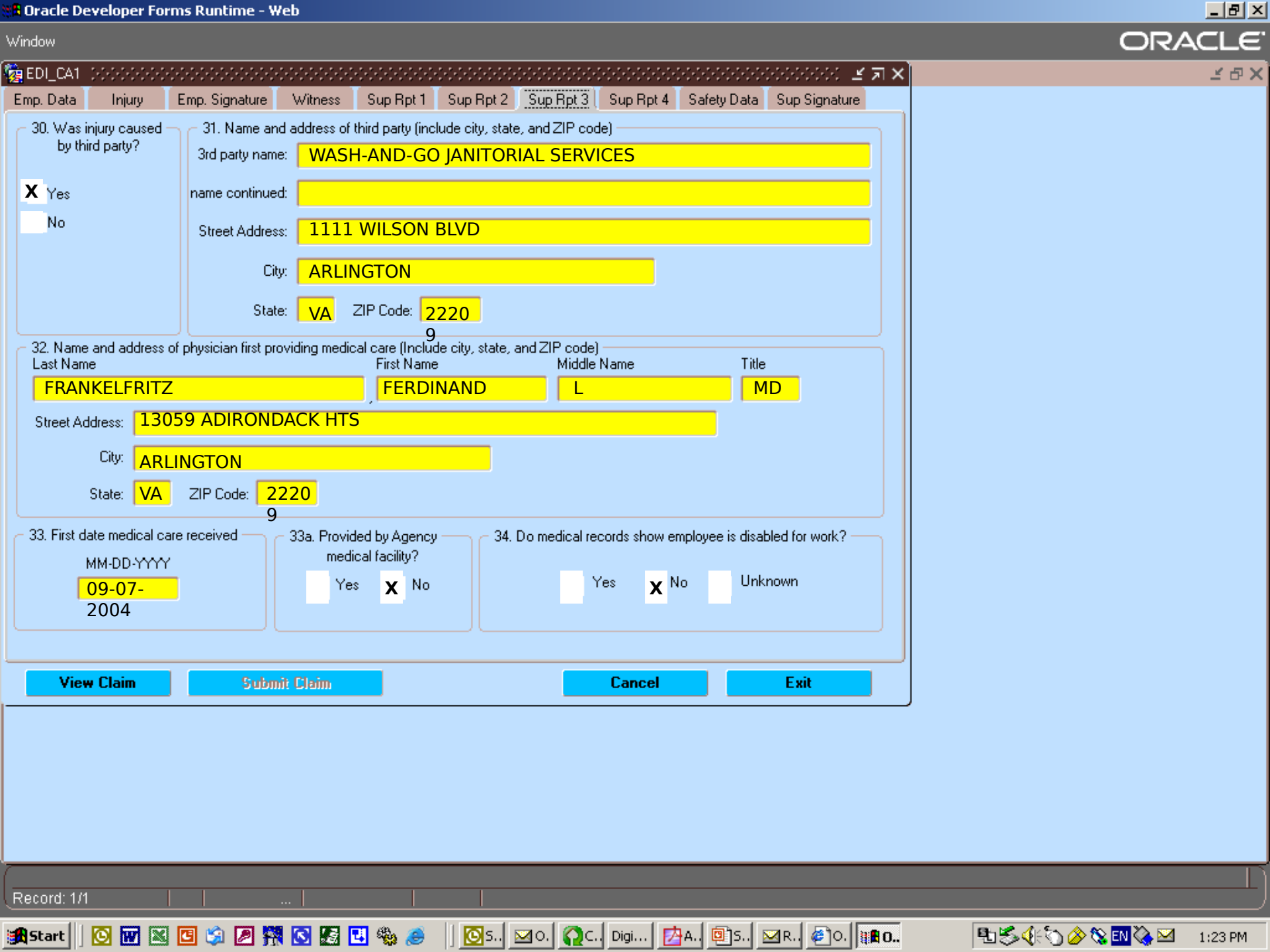
EMPLOYEE WAS WALKING INTO THE BUILDING FROM AN AUTHORIZED BREAK BUT WAS NOT PERFORMING ANY DUTIES AT THAT TIME.

29. Was injury caused by employee's willful misconduct, intoxication, or intent to injure self or another?
☐ Yes (If "Yes", explain) ◉ No

View Claim | Submit Claim | Cancel | Exit

Record: 1/1

Start | 1:23 PM


Oracle Developer Forms Runtime - Web
Window
ORACLE
EDI_CA1
Emp. Data
Injury
Emp. Signature
Witness
Sup Rpt 1
Sup Rpt 2
Sup Rpt 3
Sup Rpt 4
Safety Data
Sup Signature
30. Was injury caused by third party?
X Yes
No
31. Name and address of third party (include city, state, and ZIP code)
3rd party name: WASH-AND-GO JANITORIAL SERVICES
name continued:
Street Address: 1111 WILSON BLVD
City: ARLINGTON
State: VA ZIP Code: 22209
32. Name and address of physician first providing medical care (Include city, state, and ZIP code)
Last Name
First Name
Middle Name
Title
FRANKELFRITZ
FERDINAND
L
MD
Street Address: 13059 ADIRONDACK HTS
City: ARLINGTON
State: VA ZIP Code: 22209
33. First date medical care received
MM-DD-YYYY
09-07-2004
33a. Provided by Agency medical facility?
Yes
X No
34. Do medical records show employee is disabled for work?
Yes
X No
Unknown
View Claim
Submit Claim
Cancel
Exit
Record: 1/1
Start
1:23 PM

Oracle Developer Forms Runtime - Web

Window

ORACLE

EDI_CA1

Emp. Data | Injury | Emp. Signature | Witness | Sup Rpt 1 | Sup Rpt 2 | Sup Rpt 3 | Sup Rpt 4 | Safety Data | Sup Signature

35. Does your knowledge of the fact about this injury agree with statements of the employee and/or witness?

[ ] Yes [X] No (If "No", explain)

THERE IS SOME DISPUTE THAT THIS INJURY OCCURRED IN THE MANNER IN WHICH MR TEST INDICATES. ALTHOUGH THERE IS A WITNESS STATEMENT, IT IS FROM A FORMER EMPLOYEE WHO WAS NOT IN THE BUILDING ON OFFICIAL BUSINESS AT THE TIME THIS INCIDENT OCCURRED.

36. If the employing agency controverts continuation of pay, state the reason in detail.

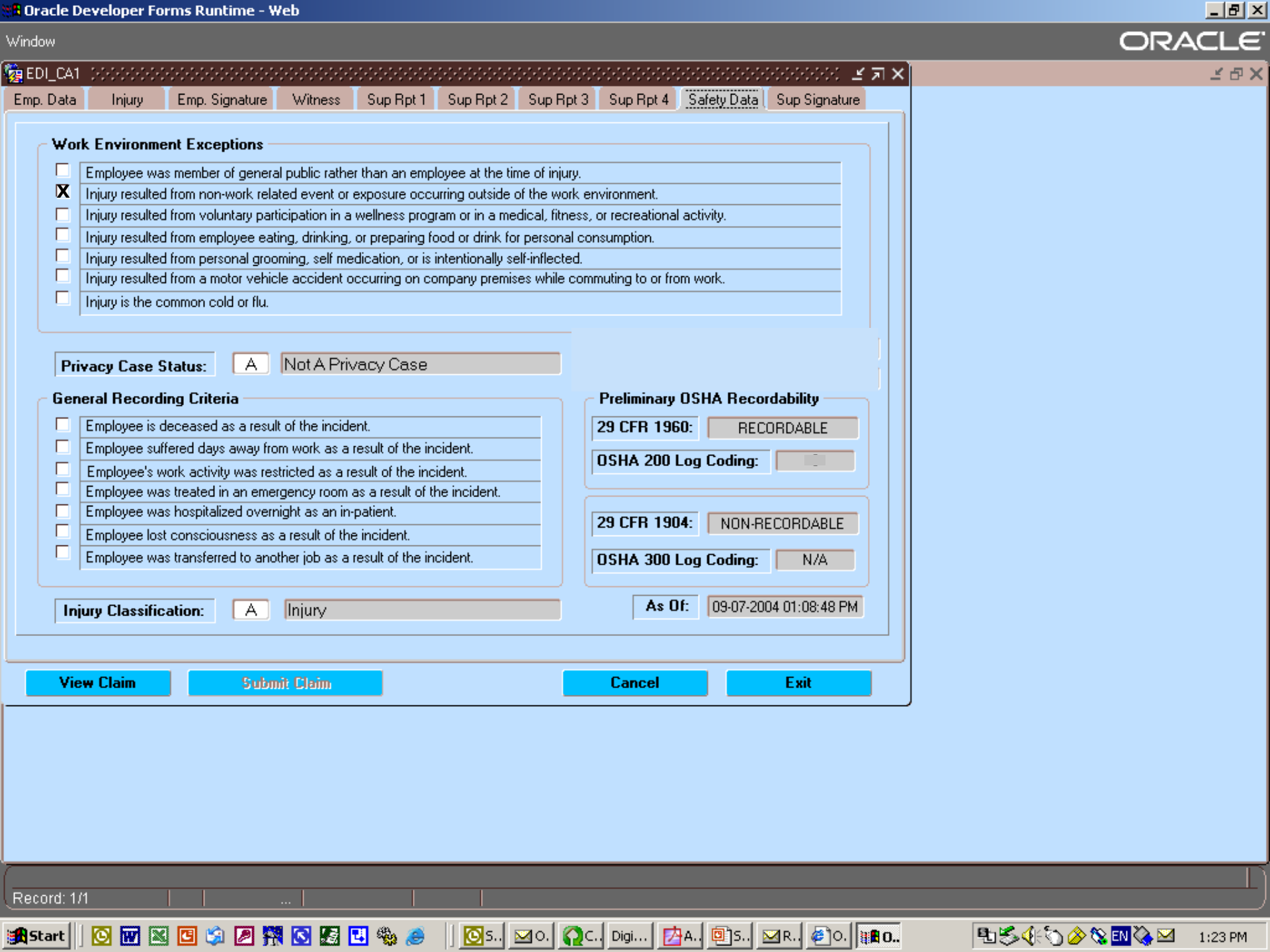
37. Pay rate when employee stopped work

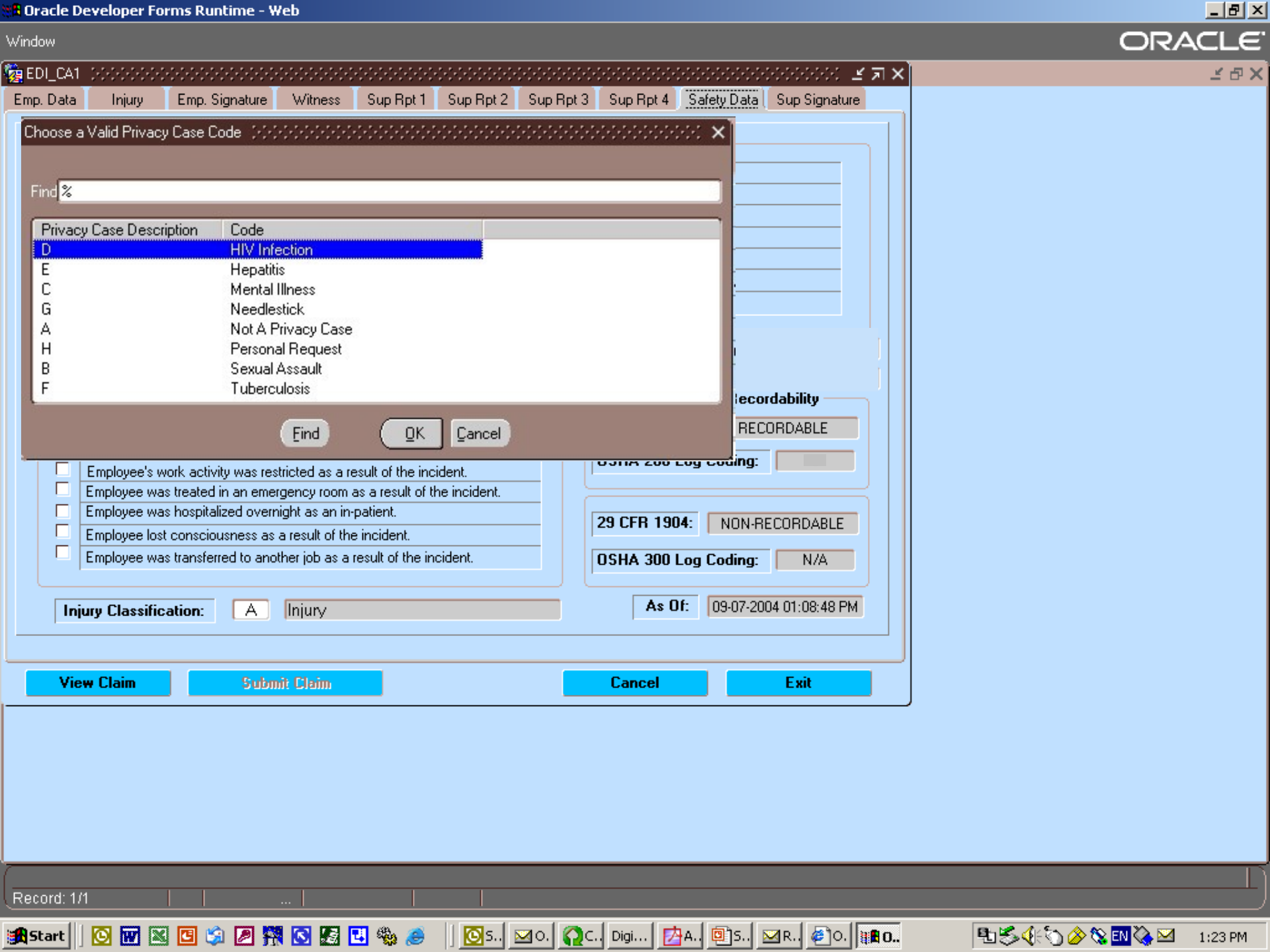
Amount: $25.25 Per: HOUR

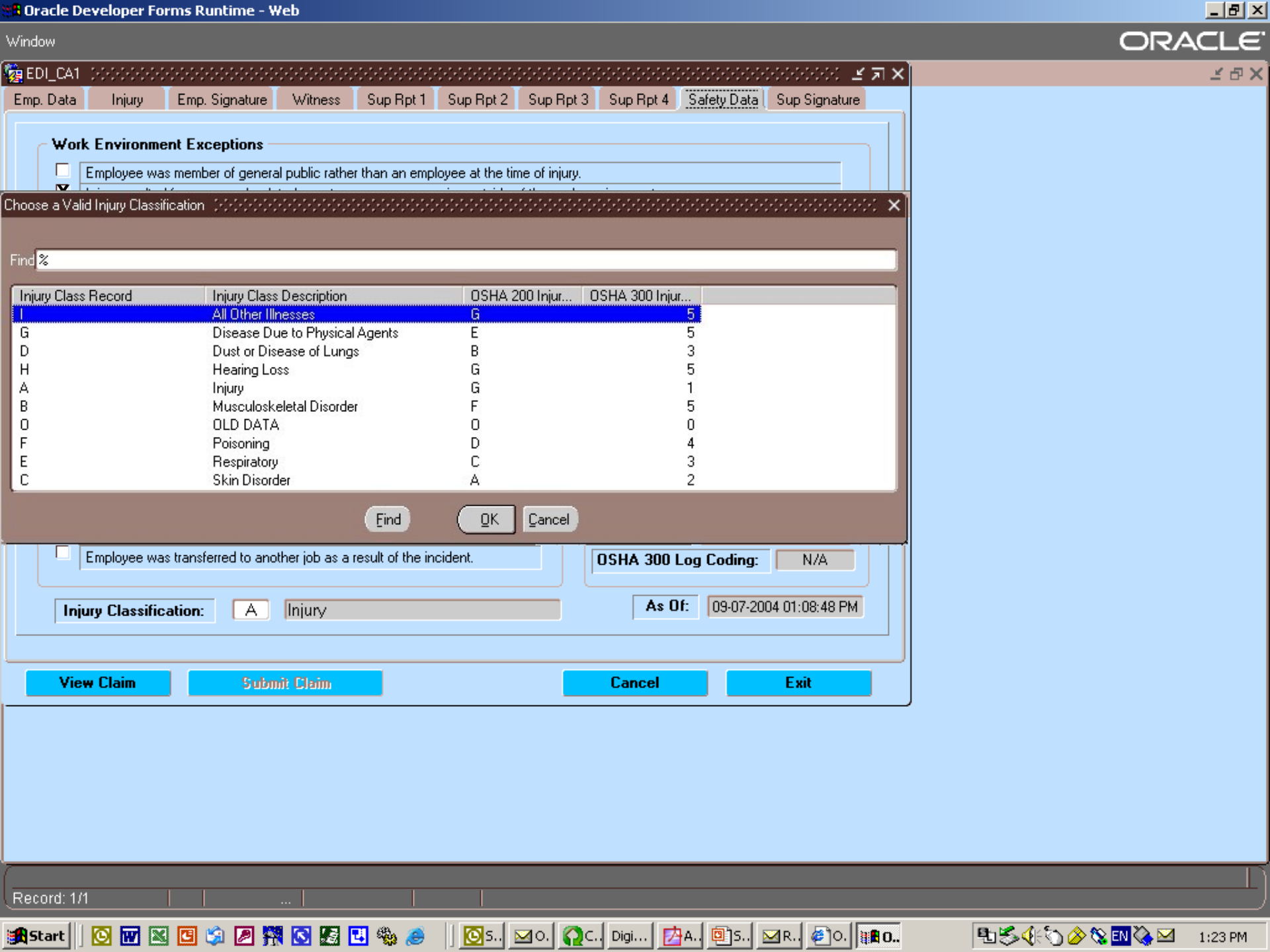
View Claim | Submit Claim | Cancel | Exit

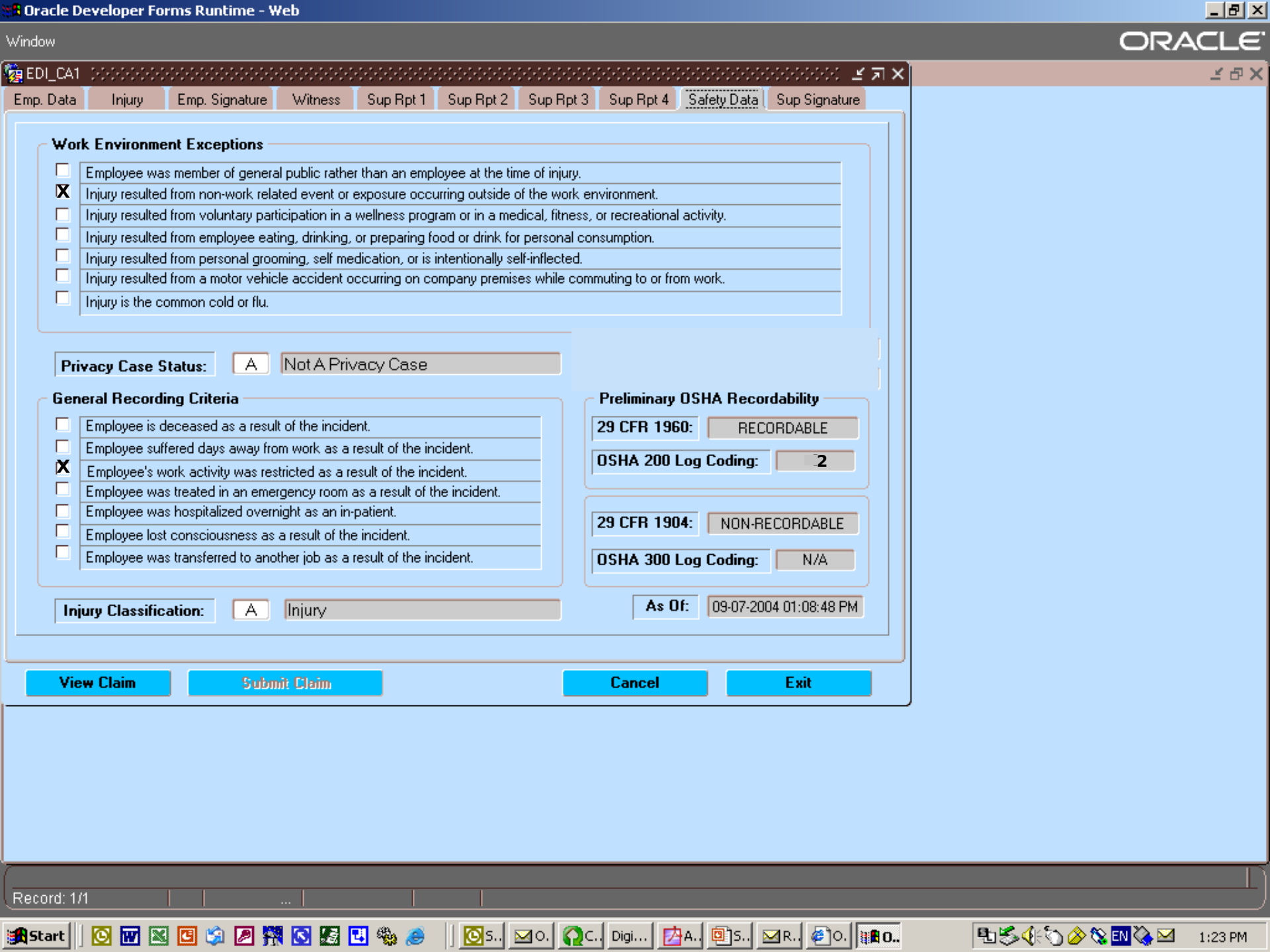
Record: 1/1

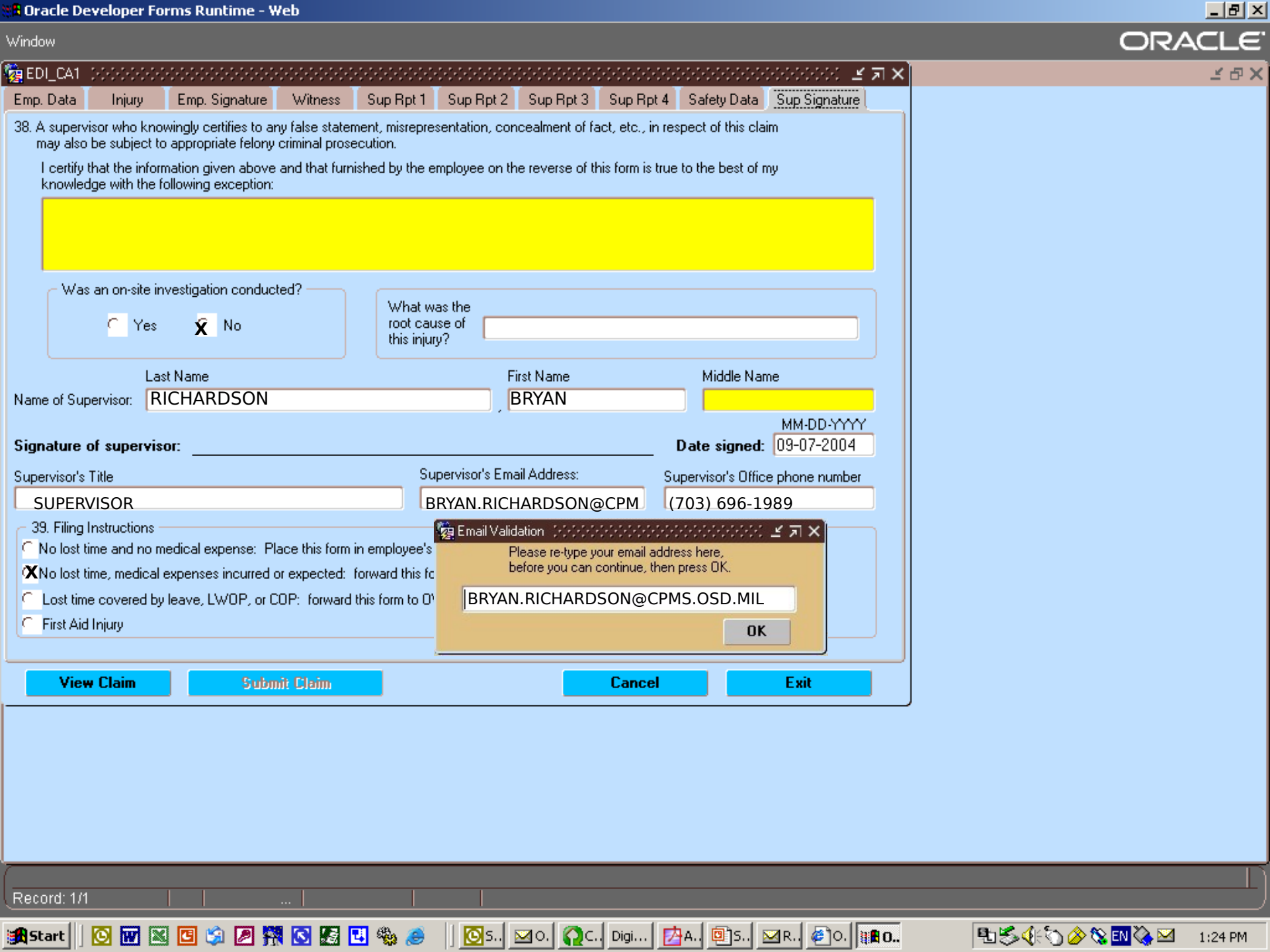
Start 1:23 PM


Oracle Developer Forms Runtime - Web
Window
ORACLE
EDI_CA1
Emp. Data
Injury
Emp. Signature
Witness
Sup Rpt 1
Sup Rpt 2
Sup Rpt 3
Sup Rpt 4
Safety Data
Sup Signature
Work Environment Exceptions
Employee was member of general public rather than an employee at the time of injury.
X
Injury resulted from non-work related event or exposure occurring outside of the work environment.
Injury resulted from voluntary participation in a wellness program or in a medical, fitness, or recreational activity.
Injury resulted from employee eating, drinking, or preparing food or drink for personal consumption.
Injury resulted from personal grooming, self medication, or is intentionally self-inflected.
Injury resulted from a motor vehicle accident occurring on company premises while commuting to or from work.
Injury is the common cold or flu.
Privacy Case Status:
A
Not A Privacy Case
General Recording Criteria
Employee is deceased as a result of the incident.
Employee suffered days away from work as a result of the incident.
Employee's work activity was restricted as a result of the incident.
Employee was treated in an emergency room as a result of the incident.
Employee was hospitalized overnight as an in-patient.
Employee lost consciousness as a result of the incident.
Employee was transferred to another job as a result of the incident.
Preliminary OSHA Recordability
29 CFR 1960:
RECORDABLE
OSHA 200 Log Coding:
29 CFR 1904:
NON-RECORDABLE
OSHA 300 Log Coding:
N/A
Injury Classification:
A
Injury
As Of:
09-07-2004 01:08:48 PM
View Claim
Submit Claim
Cancel
Exit
Record: 1/1
Start
1:23 PM


Oracle Developer Forms Runtime - Web
Window
ORACLE
EDI_CA1
Emp. Data
Injury
Emp. Signature
Witness
Sup Rpt 1
Sup Rpt 2
Sup Rpt 3
Sup Rpt 4
Safety Data
Sup Signature
Choose a Valid Privacy Case Code
Find %
Privacy Case Description
Code
D HIV Infection
E Hepatitis
C Mental Illness
G Needlestick
A Not A Privacy Case
H Personal Request
B Sexual Assault
F Tuberculosis
Find
OK
Cancel
Employee's work activity was restricted as a result of the incident.
Employee was treated in an emergency room as a result of the incident.
Employee was hospitalized overnight as an in-patient.
Employee lost consciousness as a result of the incident.
Employee was transferred to another job as a result of the incident.
RECORDABLE
29 CFR 1904:
NON-RECORDABLE
OSHA 300 Log Coding:
N/A
Injury Classification:
A
Injury
As Of:
09-07-2004 01:08:48 PM
View Claim
Submit Claim
Cancel
Exit
Record: 1/1
Start
1:23 PM


Oracle Developer Forms Runtime - Web
Window
ORACLE
EDI_CA1
Emp. Data
Injury
Emp. Signature
Witness
Sup Rpt 1
Sup Rpt 2
Sup Rpt 3
Sup Rpt 4
Safety Data
Sup Signature
Work Environment Exceptions
Employee was member of general public rather than an employee at the time of injury.
Choose a Valid Injury Classification
Find %
Injury Class Record
Injury Class Description
OSHA 200 Injur...
OSHA 300 Injur...
I All Other Illnesses G 5
G Disease Due to Physical Agents E 5
D Dust or Disease of Lungs B 3
H Hearing Loss G 5
A Injury G 1
B Musculoskeletal Disorder F 5
O OLD DATA O 0
F Poisoning D 4
E Respiratory C 3
C Skin Disorder A 2
Find
OK
Cancel
Employee was transferred to another job as a result of the incident.
OSHA 300 Log Coding:
N/A
Injury Classification:
A
Injury
As Of:
09-07-2004 01:08:48 PM
View Claim
Submit Claim
Cancel
Exit
Record: 1/1
Start
1:23 PM


Oracle Developer Forms Runtime - Web
Window
ORACLE
EDI_CA1
Emp. Data
Injury
Emp. Signature
Witness
Sup Rpt 1
Sup Rpt 2
Sup Rpt 3
Sup Rpt 4
Safety Data
Sup Signature
Work Environment Exceptions
Employee was member of general public rather than an employee at the time of injury.
X
Injury resulted from non-work related event or exposure occurring outside of the work environment.
Injury resulted from voluntary participation in a wellness program or in a medical, fitness, or recreational activity.
Injury resulted from employee eating, drinking, or preparing food or drink for personal consumption.
Injury resulted from personal grooming, self medication, or is intentionally self-inflected.
Injury resulted from a motor vehicle accident occurring on company premises while commuting to or from work.
Injury is the common cold or flu.
Privacy Case Status:
A
Not A Privacy Case
General Recording Criteria
Employee is deceased as a result of the incident.
Employee suffered days away from work as a result of the incident.
X
Employee's work activity was restricted as a result of the incident.
Employee was treated in an emergency room as a result of the incident.
Employee was hospitalized overnight as an in-patient.
Employee lost consciousness as a result of the incident.
Employee was transferred to another job as a result of the incident.
Preliminary OSHA Recordability
29 CFR 1960:
RECORDABLE
OSHA 200 Log Coding:
2
29 CFR 1904:
NON-RECORDABLE
OSHA 300 Log Coding:
N/A
Injury Classification:
A
Injury
As Of:
09-07-2004 01:08:48 PM
View Claim
Submit Claim
Cancel
Exit
Record: 1/1
Start
1:23 PM


Oracle Developer Forms Runtime - Web
Window
ORACLE
EDI_CA1
Emp. Data
Injury
Emp. Signature
Witness
Sup Rpt 1
Sup Rpt 2
Sup Rpt 3
Sup Rpt 4
Safety Data
Sup Signature
38. A supervisor who knowingly certifies to any false statement, misrepresentation, concealment of fact, etc., in respect of this claim may also be subject to appropriate felony criminal prosecution.
I certify that the information given above and that furnished by the employee on the reverse of this form is true to the best of my knowledge with the following exception:
Was an on-site investigation conducted?
Yes
X
No
What was the root cause of this injury?
Last Name
First Name
Middle Name
Name of Supervisor:
RICHARDSON
BRYAN
MM-DD-YYYY
Signature of supervisor:
Date signed:
09-07-2004
Supervisor's Title
Supervisor's Email Address:
Supervisor's Office phone number
SUPERVISOR
BRYAN.RICHARDSON@CPM
(703) 696-1989
39. Filing Instructions
No lost time and no medical expense: Place this form in employee's
X
No lost time, medical expenses incurred or expected: forward this fc
Lost time covered by leave, LWOP, or COP: forward this form to O
First Aid Injury
Email Validation
Please re-type your email address here, before you can continue, then press OK.
BRYAN.RICHARDSON@CPMS.OSD.MIL
OK
View Claim
Submit Claim
Cancel
Exit
Record: 1/1
Start
1:24 PM

Oracle Developer Forms Runtime - Web

Window

ORACLE

EDI_CA1

Emp. Data | Injury | Emp. Signature | Witness | Sup Rpt 1 | Sup Rpt 2 | Sup Rpt 3 | Sup Rpt 4 | Safety Data | Sup Signature

38. A supervisor who knowingly certifies to any false statement, misrepresentation, concealment of fact, etc., in respect of this claim may also be subject to appropriate felony criminal prosecution.

I certify that the information given above and that furnished by the employee on the reverse of this form is true to the best of my knowledge with the following exception:

Was an on-site investigation conducted?

( ) Yes (X) No

What was the root cause of this injury?

	Last Name	First Name	Middle Name
Name of Supervisor:	RICHARDSON	BRYAN	

Signature of supervisor: _____ **Date signed:** 09-07-2004 (MM-DD-YYYY)

Supervisor's Title	Supervisor's Email Address:	Supervisor's Office phone number
SUPERVISOR	BRYAN.RICHARDSON@CPM	(703) 696-1989

39. Filing Instructions

( ) No lost time and no medical expense: Place this form in employee's medical folder (SF-66-D)

(X) No lost time, medical expenses incurred or expected: forward this form to OWCP

( ) Lost time covered by leave, LWOP, or COP: forward this form to OWCP

( ) First Aid Injury

View Claim | Submit Claim | Cancel | Exit

Record: 1/1

Start 1:24 PM

OSHA Log # 900000042: was submitted for approval on 09-07-04 - Message (HTML) - Unicode (UTF-8)

File Edit View Insert Format Tools Actions Help

Reply Reply to All Forward

From: john.sterbenz@cpms.osd.mil
Sent: Tue 9/7/2004 11:47 AM
To: BRYAN.RICHARDSON@cpms.osd.mil; vinod.kambham@cpms.osd.mil
Cc: sherrel.enix@cpms.osd.mil
Subject: OSHA Log # 900000042: was submitted for approval on 09-07-04

This is to notify you that a new workers' compensation claim has been filed. The attachment noted below contains the OSHA 101 and 301 Incident Report captured through the Electronic Data Interchange Process.

The initial OSHA recordability for this case is show below.

OSHA Recordability -	29CFR 1960 Recordable	2
	29CFR 1904 Non-Recordable	N/A

OSHA101_3...
(22KB)

Start | EDI Approval Notification... | OSHA Log # 90000004... | 12:20 PM

Adobe Acrobat Professional - [OSHA101_301.pdf]
File Edit View Document Tools Advanced Window Help
Open Save Print Email Search Create PDF Review & Comment Secure Sign Advanced Editing
Select Text 118% How To..?
Bookmarks Signatures Layers Pages Comments

Occupational Safety and Health Amination
Supplementary Record of
Occupational Injuries and Illnesses

U.S. Department of Labor

This form is required by Public Law 91-596 and must be kept in the establishment for 5 years. Failure to maintain can result in the issuance of citations and assment of penalties.

Case or File No. 900000042
OSHA Recordability - 1960 Recordable 2
1904 Non-Recordable N/A

Forms Approved
O.M.B No.1218-0176

See OMB Disclosure Statement on reverse.

Employer

1. Name
DHRA - ICUC

2. Mail address (No. and street, city or town State, and zip code)
1400 KEY BLVD STE 600 ARLINGTON VA 22209

3. Location, if different from mail address
IN FRONT WALKWAY AT 1400 KEY BLVD, ARLINGTON VA 22209

Injured or Ill Employee

4. Name (First, middle, and last)
ACTION TEST

Social Security No.
111-11-1111

5. Home address (No. and street, city or town, State, and zip code)
1303 HOLLY ST WASHINGTON DC 20012

6. Age 37

7. Sex (Check one) Male [X] Female [ ]

8. Occupation (Enter regular job title, not the specific activity he was perfoming at the time of injury.)
0203 -- PERSONNEL ACTIONS CLERK (DATA TRANSCRIBING)

9. Department (Enter name of department or division in which the injured person is regularly employed, even though he may have been temporarily working in another department at the time of injury.
DD

The Accident or Exposure to Occupational Illness

If accident or exposure occured on employer's premises, give address of plant or establishment in which it occurred. Do not indicated department or division within the plant or establishment. If accident occurred outside employer's premises at an identifiable address, give that address. If it occurred on a public highway or at any other place which cannot be identified by number and street, please provide place references locating the place of injury as accurately as possible.

10. Place of accident or exposure (No. and street, city or town, State, and zip code)
IN FRONT WALKWAY AT 1400 KEY BLVD, ARLINGTON VA 22209

8.5 x 11 in
1 of 2
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OSHA's Form 301

Injury and Illness Incident Report

Attention: This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employee to the extent possible while the information is being used for occupational safety and health purposes.

OSHA Recordability - 1980 Recordable 2
1904 Non-Recordable N/A

U.S. Department of Labor
Occupational Safety and Health Administration

Form approved OMB no. 1219-0176

This Injury and Illness Incident Report is one of the first forms you must fill out when a recordable work-related injury or illness has occurred. Together with the Lof of Work-Related Injuries and Illnesses and the accompanying Summary, these forms help the employer and OSHA develop a picture of the extent and severity of worked-related incidents.

Within 7 calendar days after you receive information that a recordable work-related injury or illness has occurred, you must fill out this form or an equivalent. Some state workers' compensation, insurance, or other reports may be acceptable substitutes. To be considered an equibalent form, any subsitute must contain all the information asked for on this form.

According to Public Law 91-596 and 29 CFR 1904, OSHA's recordkeeping rule, you must keep this form on file for 5 years following the year to which it pertains.

If you need additional copies of the form, you may photocopy and use as many as you need.

Completed by BRYAN RICHARDSON
Title SUPERVISOR
Phone (703) 696 - 1989 Date 09/07/04

Information about the employee

1) Full name ACTION TEST
2) Street 1303 HOLLY ST
City WASHINGTON State DC Zip 20012
3) Date of birth 08/01/1966
4) Date hired 01/01/1982
6) [X] Male
[ ] Female

Information about the physician or other Health care professional

8) Name of physician or other health care professional
FERDINAND FRANKELFRITZ 13059
ADIRONDACK HTS ARLINGTON VA 22202
7) If treatment was given away from the worksite, where was it given?
FERDINAND FRANKELFRITZ
Facility
13059 ADIRONDACK HTS
Street
ARLINGTON State VA Zip 22202
City
8) Was employee treated in an emergency room?
[ ] Yes
[X] No
9) Was employee hospitalized overnight as an in-patient?
[ ] Yes
[X] No

Information about the case

10) Case number from the Log 900000042
(Transfer the case number from the Log after you record the case.)
11) Date of injury or illness 09/05/2004
12) Time employee began work 07:00 AM AM / PM
13) Time of event 10:15 AM AM / PM [ ] Check if time cannot be determine
14) What was the employee doing just before the incident occured? Describe the activity, as well as the tools, equipment, or material the employee was using. Be specific. *Examples:* "climbing a ladder while carrying roofing materials"; "spraying chlorine from hand sprayer"; :daily computer key-entry."

WHILE WALKING INTO THE BUILDING FROM BREAK, I SLIPPED ON THE WET FLOOR. THE CUSTODIAN JUST WASHED THE MARBLE FLOOR AND IT WAS VERY SI

15) What happened? Tell us how the injury occurred. *Example:* "When ladder slipped on wet floor, worker fell 20 feet"; "Worker was sprayed with chlorine when gasket broke during replacement"; "Worker developed soreness in wrist over time."

WHILE WALKING INTO THE BUILDING FROM BREAK, I SLIPPED ON THE WET FLOOR. THE CUSTODIAN JUST WASHED THE MARBLE FLOOR AND IT WAS VERY SI

16) What was the injury or illness? Tell us the part of th ebody that was affected and how it was affected; be more specific than "hurt," "pain," or sore." *Examples:* "strained back"; "chemical burn, hand"; "carpal tunnel syndrome."

FELL ON SAME LEVEL, LEFT FOOT - GREAT TOE SINGLE LEG/HIP/ANKLE/BUTTOCK

17) What object or substance directly harmed the employee? *Examples:* "concrete floor";"chlorine"; "radial arm saw." *If this question does not apply to the incident, leave it blank.*

WALKING/WORKING SURFACE (FLOOR, STREET, CURBS, PORCHES)

18) If the employee died, when did death occur? Date of death ___/___/___

11 x 8.5 in
2 of 2
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